STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345081	A. BUILDING ______ B. WING ______	C 01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ROSE MANOR LLC	**4230 NORTH ROXBORO STREET DURHAM, NC 27704**

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F 000	INITIAL COMMENTS An unannounced onsite complauint survey was conducted 1/30/2023 through 1/31/2023. The following intakes were investigated NC00194506, NC00195057, NC00196528, NC00197494, NC00197504, NC00197668. One of the 10 allegations resulted in deficiency. Event ID#TX8T11.	F 000		
F 624 SS=D	Preparation for Safe/Orderly Transfer/Dschrg CFR(s): 483.15(c)(7) §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with resident, home healthcare Physical Therapist (PT), facility Social Worker, Nurse Practitioner (NP), and staff, the facility failed to assess the resident's home environment to identify and evaluate barriers of the discharge location and failed to verify the assessed level of caregiver support was in place for the resident's safe discharge home. This was for 1 of 3 residents (Resident #1) reviewed for discharge. The findings included: Resident #1 called the state agency on 1/23/2023 reporting he was discharged to his apartment on 1/20/2023 and stated it was not safe. He reported not having his prescriptions, could not get into his	F 624	Patient discharged to prior living quarters on 1/20/23. Social Worker set up Home Health & had referrals for therapy. Resident stated he did no need DME as he already had at home. PA wrote scripts for medication and friend transported resident to home. Called resident on 1/26/23 to invite back to facility, he stated no but possibly the beginning of next month. Administrator, called APS and Police Wellness check. Officer visited home and stated resident in good condition and safe. 2/3/23 All home discharges were reviewed to ensure a safe discharge by Director of Nursing, Administrator, Therapy Director,	2/21/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 02/17/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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bathroom with walker, and did not get 30 day notice and was not notified of appeal rights.

Resident #1 was admitted to the facility on 11/18/2023 with diagnoses that included fracture of the humerus (upper arm) and left side hemiplegia and hemiparesis following a cerebral infarct (stroke).

Resident #1's care plan, initiated 11/18/2022, included a focus area of short term stay with plan to return home.
The goal was for Resident #1 to verbalize an understanding of all discharge instructions in order to facilitate safest possible discharge by the discharge date and to have access to medical equipment and outpatient services at the time of discharge. The interventions initiated on 11/18/2022 included:
" Contact home health services of choice prior to discharge.
" Make appointments with primary care provider and other healthcare providers prior to discharge.
" Order durable medical equipment (DME) prior to discharge, to be available on discharge.

A hard copy typed document completed by the Social Worker (SW) revealed the following information:
- On 1/16/2023 the SW met with Resident #1 to inform him of a Notice of Medicare Non-Coverage (NOMNC). The SW wrote that Resident #1 had expressed his desire to go home. The SW told him that she would assist him with the discharge process and would make referrals for home health PT and Occupational Therapy (OT) and

F 624

and the Social Worker. The audit did not reveal any unsafe discharges.

Interdisciplinary Team (Administrator, Director of Nursing, Social Worker, Therapy director, Unit Coordinators, and Physicians Assistant) to review Discharges for safety prior to discharge and document findings for three months. In planning discharge the Interdisciplinary Team to offer home evaluation. These audits will be reviewed by the Administrator or his designee. The date of compliance will be 2/21/23.

These results will be brought to QAPI by the Social Worker or the administrators designee for three months or until substantial

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F 624	Continued From page 2 order any DME he needed. Resident #1 stated that he had all the equipment he needed at home, and he did not want me to make an appointment with his Primary Care Provider. On 1/30/2023 at 1:30PM an interview was conducted with the Social Worker. She stated she met with Resident #1 on 1/16/2023 to discuss plans for discharge. The resident stated the Director of Therapy Services had already discussed discharge plans with him. He stated he felt he was ready to go home and wanted to go home. She stated she offered to assist the resident with an appeal if he felt he needed it and he declined. The SW offered to schedule a follow up appointment with his Primary Care Provider, but the resident declined stating he would make the appointment himself. The SW stated she would order any DME he would need but the resident stated he had a walker and wheelchair he was using at home prior to his fall and hospitalization. He did not want any additional DME ordered. The SW stated she did not believe the resident had a roommate. She did not know if his apartment was handicap accessible or if he would need to navigate steps, but she did know the Administrator made a referral to the Department of Public Services (DPS) on 1/19/2023 to get the resident assistance with finding a handicap accessible apartment and assistance with care at home. She further stated the resident was getting meals on wheels prior to his admission and he stated he already called meals on wheels to resume his service once he got home. The SW stated she felt this was a safe discharge. She did not request or offer to conduct a home visit. The SW stated she was not aware SWs made home visits as part of the discharge process. She further stated in her experience at	F 624		

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previous facilities, home visits were completed by therapy services if they were needed.

An OT discharge summary for services from 11/21/2022 through 1/19/2023 indicated Resident #1 was independent with dressing, bathing, and transfers needing increased time and modifications for non-weight bearing status. The resident was noted to have met all goals. The discharge location documented on the OT discharge summary was "home with support". The recommendations were to continue outpatient OT.

A PT discharge summary for services from 11/21/2022 through 1/17/2023 indicated Resident #1 met all goals. He was able to safely ambulate independently 90-100 feet using a rollator on level and uneven surfaces and could ascend/descend 10 steps using touching assistance. Discharge recommendations included rollator for short distances within the house and wheelchair for community mobility and continue PT with home health.

A speech and language (SLP) discharge summary for services 11/21/2022 through 1/17/2023 indicated the resident met all goals prior to discharge and his cognitive skills were withing functional limitations. The discharge location was home and recommendations were to continue home health therapy services. The SLP discharge summary indicated the resident's prognosis was "good with strong family support".

The Nurse Practitioner's (NP) discharge summary dated 1/20/2023 indicated the resident was being seen at staff request with report of plans to discharge home. Resident #1 reported to

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F 624	Continued From page 4 NP that he was returning to his own apartment. The NP discharge summary indicated he spoke with the SW regarding previously written orders for home health to include PT and OT as well as prescription refill for all medications (30 day supply). NP discussed discharge plan with SW, nursing staff and the resident. The NP also discussed discharge plans with the Medical Director who also agreed. The resident's medical record revealed a Physician's orders for Resident #1 dated 1/19/2023 Home healthcare referral for PT, and OT. The discharge Minimum Data Set (MDS) assessment date 1/20/2023 indicated Resident #1s cognition was intact. He had no behaviors. Resident #1 required supervision for transfers, walking, eating, and toileting. He required limited assistance with dressing and personal hygiene. He was dependent on assistance from others for showering/bath. The resident's discharge performance was not coded on the discharge MDS dated 1/20/2023. The resident did not have any falls or pressure injuries. Resident #1 received diuretic medication 7 out of 7 days and he received Physical Therapy (11/21/2022 through 1/17/2023), Occupational Therapy (11/21/2022 through 1/19/2022), and Speech Therapy (11/21/2022-1/19/2023). He was not coded for use of wheelchair. On 1/30/2023 at 12:30PM and interview was conducted with the NP. He stated he was very familiar with the resident and completed his discharge assessment and summary on 1/19/2023. He stated the resident was	F 624		

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independent with activities of daily living, continent of bowel and bladder, and met his therapy goals. The resident verbalized his wish to return home. The NP stated he felt it was a safe discharge.

The Director of Rehab services was interviewed on 1/30/2023 at 12:45 PM . She stated she was very familiar with the resident and stated he made good progress in therapy. He was known to refuse therapy due to his desire to stay outside smoking. Then he would come into the therapy gym unscheduled and request service. However, he did meet his goals, was independent with activities of daily living and safe to return to his previous living arrangement. She was aware he had a roommate and that the roommate did not provide assistance with care. The resident was able to navigate short distances with a walker and used a wheelchair for long distances when in the facility. If there had been a concern regarding the resident's ability to access his apartment or navigate stairs, the therapy team would determine if a home visit was warranted. The Director of Rehab stated the resident only had one step to navigate to get into his apartment and he was able to navigate that easily in the therapy gym. He was able to ambulate a distance of 90-100 feet with a wheeled walker and had a wheelchair for locomotion outside of his apartment in the community. She did not see a reason for a home visit.

On 1/30/2023 at 3:30PM an interview was conducted with Resident #1 who had just been readmitted to the facility. The resident stated prior to his discharge on 1/20/23 he wanted to discharge home and thought he could care for

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F 624	Continued From page 6 himself at home. He had been doing so prior to his fall and hospitalization. He further stated it was harder than he thought it was going to be. He was unable to ambulate the distance from his bedroom to his kitchen or bathroom without difficulty. He essentially stayed in his bedroom all day. On one occasion he could not get to the bathroom fast enough which resulted in him not getting to the bathroom in time. He did have a bowel movement while trying to get to the bathroom. He soiled his clothing and the floor in his kitchen. He was not able to clean the floor in the kitchen for fear he was going to fall. He stated he did have a roommate, but his roommate did not assist him with care. He had a friend pick him up from the facility and the same friend checked on him daily. The friend stocked his kitchen cabinets and refrigerator with food the day he discharged. He stated he was wiping himself off at the sink because he had a tub/shower and could not safely step into the shower. He stated he did not have anyone coming into the home to help him with bathing or personal hygiene. Resident #1 stated he had written scripts for his medication at the time of his discharge and he had the facility fax them to his pharmacy. When his friend went to pick up his medication, the medications were not ready and his friend did not wait. He stated he had medications at home from prior to his admission. He took those medications. A phone interview was conducted with the Home Health PT on 1/31/2023 at 10:27 AM. The PT stated he called the resident on 1/24/2023 to initiate services. The resident stated the door to the apartment was unlocked. The PT stated the apartment was very dirty and smelled of alcohol and feces. The trash can was overflowing, and	F 624		

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the apartment was cluttered. The PT stated Resident #1 was not accepted for care due to several safety concerns.
" The resident had consumed alcohol and smelled of alcohol.
" There was feces smeared on the floor in the kitchen of the apartment.
" The apartment was cluttered, presented a safety risk for ambulation with a rollator.
" A primary caretaker must be in the home to initiate services and the resident indicated he did not have any assistance.

The Home Health PT stated the resident told her he did not make it to the bathroom in time and had an accident on himself. He was able to clean himself up but was not able to clean the floor in the kitchen very well. The PT stated Resident #1's Primary Care Provider (PCP)was made aware he was not accepted for care and she also made her supervisor aware.

A second interview was conducted with Resident #1 on 1/31/2023 at 11:30AM. He stated he returned to the facility because he did not want to be confined to his bedroom all the time. He did not wish to stay in the facility. He would like to try more rehab and go out to an assisted living facility once he was stronger. He would like a facility that would allow him to smoke. He further stated he felt like he could have stayed home if the home health had provided therapy like planned.

On 1/31/2023 an interview was conducted with the Administrator. He stated he was made aware of the situation on 1/26/2023 when a member of the state survey team called and made him aware. He then called the police department to

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F 624	Continued From page 8 check on the resident. The police department conducted the visit and advised him the resident was in good condition. He further stated he reached out to Resident #1 on 1/26/2023 and offered to facilitate transport back to the facility. The resident stated he wished to stay in his apartment and would consider returning to the facility at the end of the month or the first of the following month. The Administrator stated he was not contacted by the Home Health PT or anyone from the home health agency reporting that services were not going to be initiated. He called the resident daily to check on him and on 1/30/2023 the resident agreed to return. He has instructed the SW to assist the resident in applying for Medicaid. He further stated he felt the discharge was safe. There were no indications the facility needed to conduct a home visit.	F 624		